EVERY TEXAN

Formerly Center for Public Policy Priorities

To: House Committee on Public Health

Submitted via e-mail to PublicHealth@house.texas.gov

From:
Anne Dunkelberg, Associate Director, on behalf of
Every Texan (formerly CPPP)
7020 Easy Wind Drive, #200
Austin, TX 78752

Every Texan (formerly Center for Public Policy Priorities) appreciates the opportunity to respond to the Request for Information from the House Committee on Appropriations Subcommittee on Article II. We focus on policies that will enable Texans of all backgrounds to thrive. The Benedictine Sisters of Boerne, Texas, founded Every Texan (formerly CPPP) in 1985 to advance public policy solutions for expanding access to health care. We became an independent, tax-exempt organization in 1999. Today, we prioritize policies that will measurably improve equity in and access to health care, food security, education, and financial security. We are based in Austin, Texas, and work statewide.

Topics: This document addresses the HPH Interim Charge #2. As requested by the committee, response to other charges will be submitted in separate documents.

Interim Charge # 2. Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: Family First Prevention Services Act, the next phase of the 1115 Healthcare Transformation and Quality Improvement Program Waiver, Texas' Targeted Opioid Response Grant, the Centers for Medicare and Medicaid Services proposed Medicaid Fiscal Accountability rule, and the Healthy Texas Women Section 1115 Demonstration Waiver. ***(Joint charge with the House Committee on Human Services and the House Committee on Public Health)***

This comment is focused on the Texas Medicaid 1115 Transformation Waiver (and the now-withdrawn MFAR proposed regulation), and on how today's complex layering and methods of finance for Texas Medicaid supplemental payments to providers are inseparable from the topics of 1115 waiver transition, Texas Medicaid methods of finance, and any future Medicaid expansion.

Every Texan staff have had the opportunity to monitor from inception the implementation and ongoing operations of Texas' Healthcare Transformation and Quality Improvement Program 1115 waiver. As has been widely acknowledged, the waiver has provided a range of valuable and innovative service delivery models across Texas through the Delivery System Reform Incentive Payment (DSRIP) half of the waiver. With the end of the Texas 1115 DSRIP pool on September 30, 2021, the communities who have benefitted from new levels of access to preventive care, chronic care, and most notably mental health care are expected to experience a significant loss of capacity to serve both their insured and uninsured residents.

When federal Medicaid authorities approved the Texas 1115 in December 2011 and consistently thereafter, officials stressed that DSRIP should not be considered an ongoing funding mechanism. Instead, Texas was directed that innovations tested in DSRIP and found successful should be integrated into Texas Medicaid Managed Care benefits and service delivery models, and financed through standard Medicaid service delivery methodologies. But, because the Texas Legislature has thus far chosen to limit Medicaid coverage of adults to a

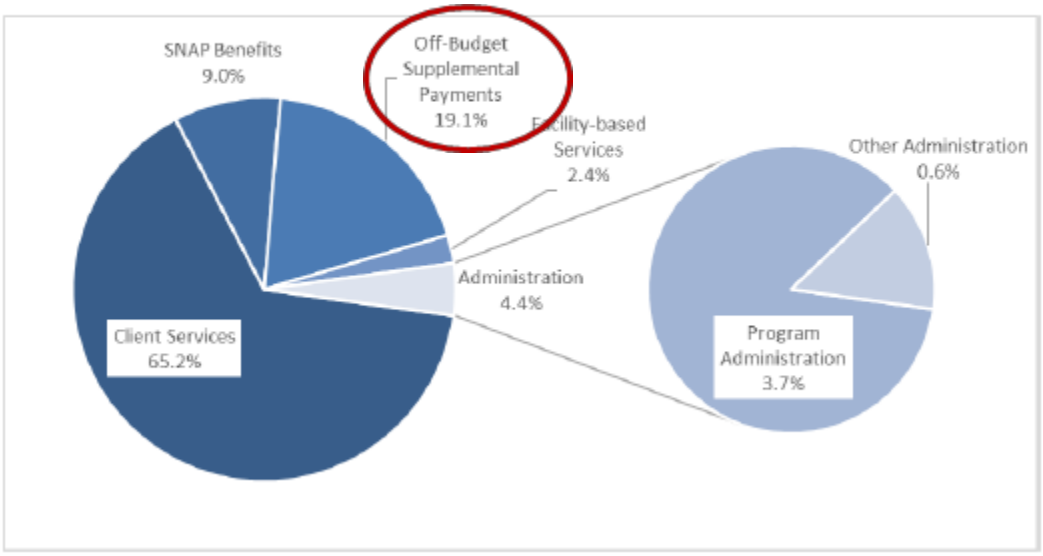
tiny handful of parents (only 151,000 parents covered in June 2020, compared to 3.1 million children in Texas Medicaid) and temporary Maternity coverage, there is essentially no way to build DSRIP innovations for most uninsured adults into Texas Medicaid.

Beyond the loss of DSRIP, the "other half" of Texas' 1115 waiver, the Uncompensated Care (UC) pool, has been downsized by federal Medicaid authorities to end the practice of using that pool to guarantee hospitals payments for their Texas Medicaid patients that are on par with Medicare rates. The establishment and rapid proliferation of the Regional Uniform Hospital Rate Increase Programs (UHRIP) came about to provide a means to continue to pay rates reasonably related to costs to Texas hospitals, through the UHRIP program which is not part of the 1115 waiver.

The entire 1115 waiver—both UC and DSRIP—has relied almost entirely on local tax-dollar funds (intergovernmental transfers or "IGT") and local/regional assessments on health care providers called Local Provider Participation Funds (LPPFs). These funding sources, not Texas G.R., provide the non-federal share of the 1115 waiver (DSRIP and UC) along with the match for DSH, UHRIP, and NAIP. Texas experts have recently estimated that at least 60% of what Texas hospitals receive from Medicaid is no longer matched with state GR funds that are reflected in the General Appropriations Act, but instead with local dollars from IGT and LPPFs. ***[Note: the withdrawal by the Centers for Medicare and Medicaid Services of the proposed Medicaid Fiscal Accountability Rule is good news for Texas' Medicaid program, and that of nearly every other state. If adopted, this rule would have virtually eliminated Texas' ability to use these off-budget revenues.]***

https://hhs.texas.gov/sites/default/files/documents/about-hhs/budget-planning/state-tx-agencies-budget-reduction-amended.pdf

Figure 1. Health and Human Services Commission All Funds Appropriations – Client Services, Facility-based Services, Administration, Funds Outside of 2020-21 General Appropriations Act Breakout (2020-21 Biennium)



The graphic above, reproduced from the Texas HHSC September 2020 revised proposal for a 5% budget cut, reflects that over 19% of dollars allocated through HHSC-administered programs (which Medicaid dominates fiscally) are now off budget. Texas' urban counties and groups of providers are financing a growing share of Texas Medicaid, compensating for the state Legislature's ongoing downward pressure on Medicaid provider payments (*see also Every Texan's comments submitted on Interim Charge #1 for this subcommittee*).

Federal Funds Foregone. Of key importance is that these local IGT and LPPF dollars are matched at "standard" Medicaid match rates (federal share will be 61.81 cents of each client service dollar for FY 2021, after the end of the current federal public health emergency (PHE).* **If Texas were to expand Medicaid to cover adults below or just above the poverty line, GR dollars, IGT, and LPPF funds alike could draw a much larger 90% matching rate for the expansion population.** This would be true whether implemented under a simple Medicaid "state plan amendment" as New Mexico and Louisiana have done, or under 1115 waiver authority as Arkansas has done.

On the other hand, without a Medicaid expansion, the innovative delivery reforms and improved access to primary and preventive care under DSRIP projects will largely disappear, and Texas taxpayers will continue to lose out on the available federal matching dollars for Medicaid expansion (recent estimates[i] range from $5.4 billion to over $10 billion a year in net new federal funds, due to different assumptions about the level of voluntary enrollment). Texas' 1115 waiver can and should be renewed to add a Medicaid expansion that is designed to incorporate the top successes of the DSRIP program. **One of the recent studies cited above projects that the net savings to GR and state revenue gains if Texas takes that step will be larger than the states' 10% "non-federal" share**.

Other new reports suggest that large numbers of newly uninsured Texans have resulted from job loss due to the COVID-19 pandemic, many of whom have never before turned to public benefits. They are only now learning that they are excluded from both Medicaid and the Affordable Care Act Marketplace subsidies. The Kaiser Family Foundation estimates that 1.6 million Texans of all ages had already lost employer coverage by early May 2020; presumably that number has grown in the months since then. Projecting ahead, Kaiser researchers estimate that by January 2021, nearly 800,000 more working-age adult Texans will have become uninsured and will have low enough incomes that they could be covered under a Texas Medicaid expansion (compared to before the pandemic). This would bring the number of uninsured Texas adults who could be covered under a Texas Medicaid expansion to 2.2 million.

Additional details This comment is focused in greater detail on the outsized role of supplemental payments to hospitals in Texas Medicaid, and the recently withdrawn MFAR proposed federal regulation. These comments repeat some content from Charge #2, and add new material.

Beyond the scheduled 2021 loss of DSRIP, the "other half" of Texas' 1115 waiver, the Uncompensated Care (UC) pool, has been downsized by federal Medicaid authorities to end the practice of using that pool to guarantee hospitals payments for their Texas Medicaid patients that are on par with Medicare rates. The establishment and rapid proliferation of the Regional Uniform Hospital Rate Increase Programs (UHRIP) came about to provide a means to continue to pay rates reasonably related to costs to Texas hospitals, through the UHRIP program which is not part of the 1115 waiver.

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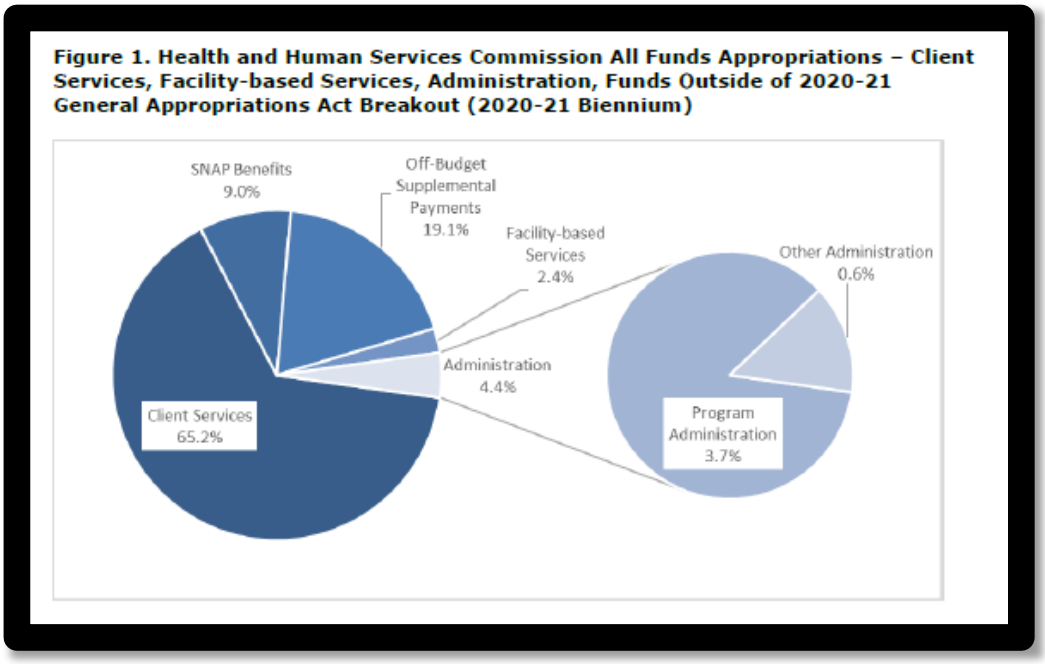
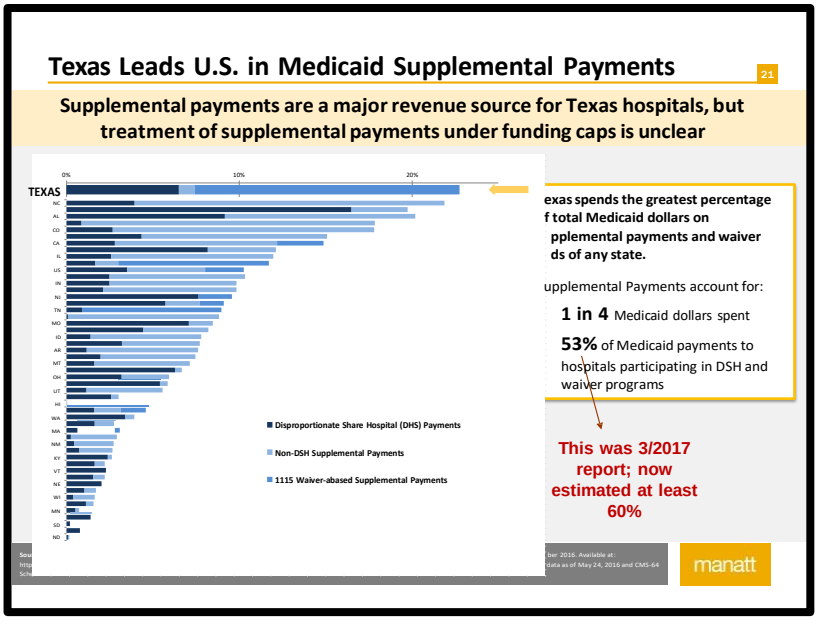


Provider Participation Funds (LPPFs). These funding sources, not Texas G.R., provide the non-federal share of the 1115 waiver (DSRIP and UC) along with the match for DSH, UHRIP, and NAIP. Texas experts have recently estimated that at least 60% of what Texas hospitals receive from Medicaid is no longer matched with state GR funds that are reflected in the General Appropriations Act, but instead with local dollars from IGT and LPPFs. ***[Note: the withdrawal by the Centers for Medicare and Medicaid Services of the proposed Medicaid Fiscal Accountability Rule is good news for Texas' Medicaid program, and that of nearly every other state. If adopted, this rule would have virtually eliminated Texas' ability to use these off-budget revenues.]***

https://hhs.texas.gov/sites/default/files/documents/about-hhs/budget-planning/state-tx-agencies-budget-reduction-amended.pdf

Growing Reliance on off-Budget funds and supplemental payments. The graphic above, reproduced from the Texas HHSC September 2020 revised proposal for a 5% budget cut, reflects that over 19% of dollars allocated through HHSC-administered programs (which Medicaid dominates fiscally) are now off budget. Texas' urban counties and groups of providers across the state are financing a growing share of Texas Medicaid, compensating for the state Legislature's ongoing downward pressure on Medicaid provider payments (*see Every Texan's comments submitted on Interim Charge #1 for this subcommittee*).



Lack of Transparency that Results. The graphic adjacent from a top national consultant showed that Texas was more reliant on Medicaid supplemental payments

than any other state in 2017, and it is unlikely that our ranking has changed significantly since then. Two big implications of this reality: (1) We are also more reliant on non-GR, off-budget funding of our "state's share" of Medicaid funding than most states, and(2) the complexity of multiple supplemental inputs into our hospitals' Medicaid payments coupled with lack of easy transparency about what those amounts are and the methods of finance for the various LPPFs make it extraordinarily hard for legislators to get an accurate picture of the degrees to which hospitals are being paid below, at or above their costs of care and the degree to which profits unrelated to delivery of care are covered. This is true for hospitals in the aggregate, and certainly also for specific hospitals in a Legislator's district.

Some Texas Medicaid providers (e.g., pharmaceutical manufacturers, managed care plans) are paid in ways that allow substantial profits, while others (therapists, mental health providers, physicians, and personal attendants) are paid rates that are far below Medicare rates., often below the actual cost of providing care, and in the case of attendant care, are below a living wage. Texas would be far better served if hospital payments for services to Medicaid enrollees provided Medicare parity (at minimum) through a single transparent methodology. In addition, uncompensated care methods will still be needed unless and until Texas sheds our current worst-in-nation uninsured number and percentage, but these payments also beg call for greater aggregation and transparency. With a clearer picture of who the "winners and losers" are among Texas Medicaid providers, it will be possible to better assess the policy changes that could bring greater equity to providers, but even more importantly could remove the barriers to preventive and primary care that today's payment systems have institutionalized.

Texas' legislative and executive branch cultures are such that the HHSC (like other state agencies) is strongly discouraged from seeking major policy changes until after the Legislature has given direction. It will only be with the initiative and leadership of the Texas Legislature and the Governor that over 2 million uninsured Texans—the vast majority with strong workforce histories—will gain comprehensive medical coverage and Texas communities large and small will be able to hold onto the hard-won gains achieved under DSRIP projects for their communities.

** Texas is projected to have already received an additional $2 billion in FMAP relief under the March 2020 FFCRA as of the end of September 2020, and that total would grow to $4.8 billion in federal matching funds if the federal PHE were extended through September 2021.*

Respectfully,
Anne Dunkelberg
Associate Director
EveryTexan.org |dunkelberg@everytexan.org
Social justice requires public policy.

Notes

[i] See reports posted at Episcopal Health Foundation from John Pitts et. al.; Bush School of Government and Public Services at Texas A&M; and DR. Ray Perryman.
https://www.episcopalhealth.org/wp-content/uploads/2020/09/Fritz-Pitts-Pitts-Sept-2020-Impact-of-Medicaid-Expansion-on-State-Budget-1.pdf
https://www.episcopalhealth.org/research-report/county-level-projections-of-medicaid-expansions-impact-in-texas/
https://www.episcopalhealth.org/research-report/economic-benefits-of-expanding-health-insurance-coverage-in-texas/